National Rural Health Association

March 13, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

RE: CMS–9883–P; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program

Submitted electronically via regulations.gov.

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on the proposed 2027 Notice of Benefits and Payment Parameters rule. We appreciate the Centers for Medicare and Medicaid Services' (CMS) continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

III. Provisions of the Proposed Regulation

CMS proposes to make changes to bronze and catastrophic plans available on the Affordable Care Act (ACA) Marketplace. These plans represent the most affordable options on the Marketplace (based on premiums) but consequently offer the least robust coverage and have extremely high deductibles. **NRHA has concerns regarding the potential for rural enrollees to switch to these less generous plans leading to underinsurance and increased medical debt. As such, we ask CMS to not finalize the proposed changes to catastrophic and bronze plans.**

CMS proposes expanding use of catastrophic plans by offering multi-year plans and broadening eligiblity. The proposed multi-year eligibility would allow enrollees to auto-enroll in these plans for up to 10 years. Catastrophic plans are currently only available to individuals under age 30 unless they receive a hardship exemption. CMS is proposing to expand the hardship exemption and allow catastrophic coverage for individuals with incomes under 100% of the federal poverty level (FPL) and over 250% FPL. CMS also

proposes to bar catastrophic plans from covering additional services beyond the three required primary care visits and free preventive care until enrollees spend 130% of their maximum out of pocket (MOOP), amounting to $15,600. For bronze plans, CMS proposes to allow insurers to raise their cost-sharing above statutory MOOP limits.

CMS states that these changes, taken together, will create cheaper coverage options for healthy individuals. However, NRHA is concerned that CMS is incentivizing enrollment in catastrophic plans by expanding eligibility and promoting auto-enrollment, which may mislead enrollees as to their best choice of coverage. While a lower monthly premium for a catastrophic or bronze plan may entice a rural individual, they may not understand the stringent limitations on coverage, the increased out of pocket costs, and the loss of eligibility for advanced premium tax credits (APTCs). Rural enrollees may choose these plans simply for the perceived affordability based on the premium and not because they are the appropriate coverage option.

Data from 2025 shows that **rural Marketplace enrollees are more likely to choose bronze plans** (35% vs. 31%) than their urban counterparts and less likely to choose silver plans (52% vs. 56%).[1] Due to large premium increases in 2026, NRHA projects that the rate of rural enrollees in a bronze plan or catastrophic plan will be much higher this year.[2] In general, premium price tends to play a significant role in individual plan selection. This is likely especially true for rural populations that on average have lower incomes and higher poverty rates.[3]

Rural enrollees who choose catastrophic and bronze plans will face significantly higher out-of-pocket costs for medical expenses under CMS' proposal. The implications are twofold with both rural individuals and providers feeling the impacts. Rural enrollees who cannot afford to pay medical bills due to higher out-of-pocket costs associated with lower tier plans will likely take on medical debt.[4] Rural hospitals or other providers may not be able to collect payment from rural patients with catastrophic or bronze plans because the individuals cannot afford to pay their bills, leading the facility to take on uncompensated care costs. Ultimately, this becomes a bad debt for the rural hospital or other provider. Rural hospitals in particular are already struggling – almost 200 have closed or stopped providing inpatient

[1] https://www.cms.gov/files/zip/2024-oep-state-metal-level-and-enrollment-status-public-use-file.zip
[2] CONGRESSIONAL BUDGET OFFICE, *Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits* (Dec. 5, 2024), https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf.
[3] U.S. DEPT. OF AGRICULTURE, *Report No. EIB-295, Rural America at a glance: 2025 edition* 16-17 (2026) (the nonmetro poverty rate is 13.7% and the metro poverty rate is 10.2%. Additionally, 90% of all high poverty counties are nonmetro) https://ers.usda.gov/sites/default/files/_laserfiche/publications/113657/EIB-295.pdf?v=42284.
[4] *See generally*, https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2026/nrha-rural-medical-debt-policy-paper.pdf

care since 2010[5] and about half operate with negative margins.[6] Adding on further uncompensated care will exacerbate this situation by leading to further service line or total facility closures and reduced rural patient access to care. For these reasons, NRHA does not support the changes CMS proposes to catastrophic and bronze plans.

One perceived benefit to expanding access to lower premium, high-deductible plans is to reduce spending. However, individuals who choose these plans for affordability reasons are more likely to reduce spending on smaller, non-emergency services, meaning that they may skip routine, outpatient visits for primary care or mental health if they have to pay out of pocket for the care. As a result of forgoing preventive care, they will in turn likely spend more on large expenditures like emergency room visits and hospitalizations that were preventable had they sought preventive care. Again, in some cases this will lead to medical debt for individuals and more uncompensated care for rural hospitals. Ultimately, this phenomenon will drive up healthcare spending in the long run.

Changes to ECPs

Currently, plans must contract with 35% of available essential community providers (ECPs), 35% of federally qualified health centers (FQHCs), and 35% of family planning providers within their service areas. In this proposed rule, CMS intends to relax these standards from 35% to 20% for all provider types. NRHA does not support this change. CMS notes that most plans contract with well above 35% of ECPs and requiring this level is an administrative burden. However, for rural populations many health care providers that serve a large proportion of low-income or medically underserved individuals fall under the ECP designation.[7] Overly narrow networks may maximize efficiency for insurers but can have a detrimental impact on rural areas due to not having enough providers to handle demand and access to services in a reasonable distance.

Dental benefits

CMS proposes to prohibit plans from covering routine, adult dental services as an essential health benefit. **NRHA strongly urges CMS against finalizing this proposal as it will reduce access to oral health care.** Offering dental coverage for rural adults that rely upon the Marketplace for health insurance is critical to helping address the differences in oral health outcomes between rural and urban residents. Rural residents are less likely to have employer-sponsored coverage and therefore more likely to be enrolled in Marketplace

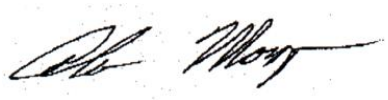
[5] CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, *Rural Hospital Closures*, (Dec. 4, 2025), https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[6] Michael Topchik et al., *2026 rural health state of the state*, Chartis Center for Rural Health (Feb. 10, 2026) https://www.chartis.com/insights/2026-rural-health-state-state.
[7] KAISER FAMILY FOUNDATION, *Definition of Essential Community Providers (ECPs) in Marketplaces*, https://www.kff.org/other/state-indicator/definition-of-essential-community-providers-ecps-in-marketplaces/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

plans.[8] Rural residents are also less likely to have dental insurance compared to urban and suburban populations.[9]

In 2019, just over half of adults in rural areas indicated that they saw a dentist in the past year, compared to 66% of metropolitan adults.[10] In terms of health outcomes, rural populations have higher percentages of those living with partial edentulism compared to urban populations.[11] Rural residents also self-report fair or poor oral health at higher rates than suburban or urban residents.[12] While factors such as geographic isolation and a lack of dental providers in rural areas may contribute to worse oral health outcomes for rural populations, a lack of dental insurance and inability to pay are also major factors. When rural residents delay care because of the latter two issues, overall health may also decline as it is well documented as being connected to oral health.[13]

NRHA thanks CMS for the opportunity to provide comments on this proposed rule. If you have any questions or would like any further information, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
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[8] Sarah Eisenstein, et al., *Health Insurance Coverage in Rural and Urban Areas in the U.S., 2023*, Brief No. 2025-5 (Sept. 2025), https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/Health_Insurance_Coverage.pdf.
[9] Paige Martin, et al., *Still Searching: Meeting Oral Health Needs in Rural Settings*, CAREQUEST INSTITUTE FOR ORAL HEALTH, 7 (Nov. 2023) https://carequest.org/wp-content/uploads/2025/10/CareQuest_Institute_Still-Searching_11.6.23.pdf.
[10] National Center for Health Statistics, *Health, United States, 2020 – 2021*, Table DentAd: Dental visits in the past year among adults aged 18 and over, by selected characteristics: United States, selected years 1997–2019, 2023, https://www.cdc.gov/nchs/data/hus/2020-2021/DentAd.pdf.
[11] Jordan Mitchell, Kevin Bennett, & Amy Brock-Martin, *Edentulism in high poverty rural counties*, 29 J. RURAL HEALTH 30, 33 (2012) https://pubmed.ncbi.nlm.nih.gov/23289652/.
[12] Martin, *supra* note 2 at 5.
[13] National Advisory Committee on Rural Health and Human Services, *Improving Oral Health Care Services in Rural America*, 3, (Dec. 2018), https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2018-oral-health-policy-brief.pdf.